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DEPARTMENT OF HEALTH
OF THE
CITY OF NEW YORK

No. 41

REPRINT SERIES

FEBRUARY, 1916

FREE MUNICIPAL CLINICS FOR SCHOOL CHILDREN

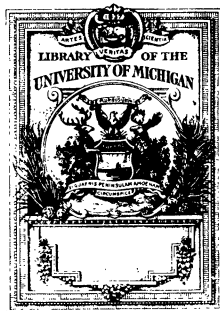
**A REVIEW OF THE WORK OF THE SCHOOL CHILDREN'S
NOSE AND THROAT CLINICS IN NEW YORK CITY
AND CONDITIONS WHICH NECESSITATE
SUCH INSTITUTIONS**

BY

J. H. BERKOWITZ



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a community can determine its own death rate."*



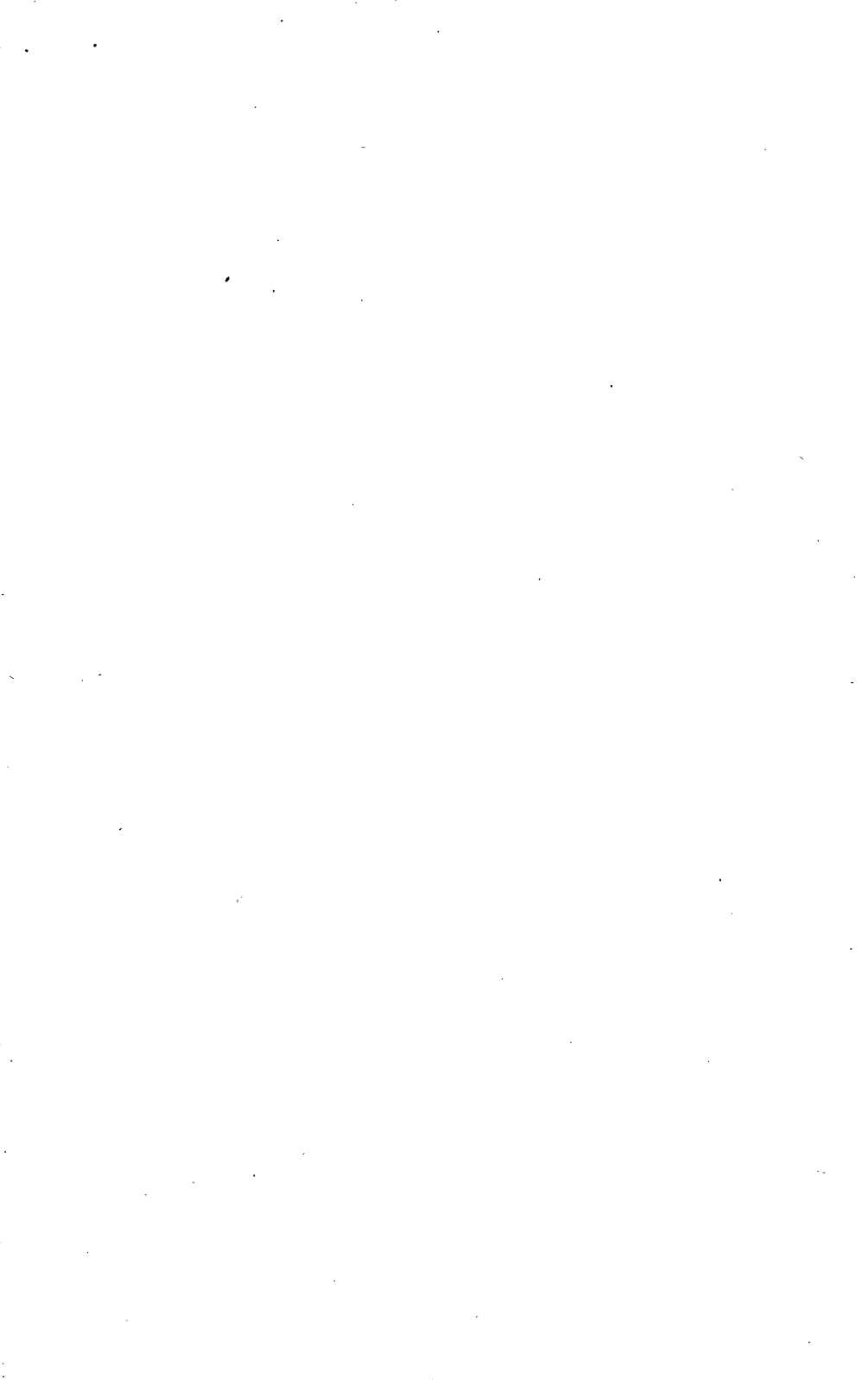
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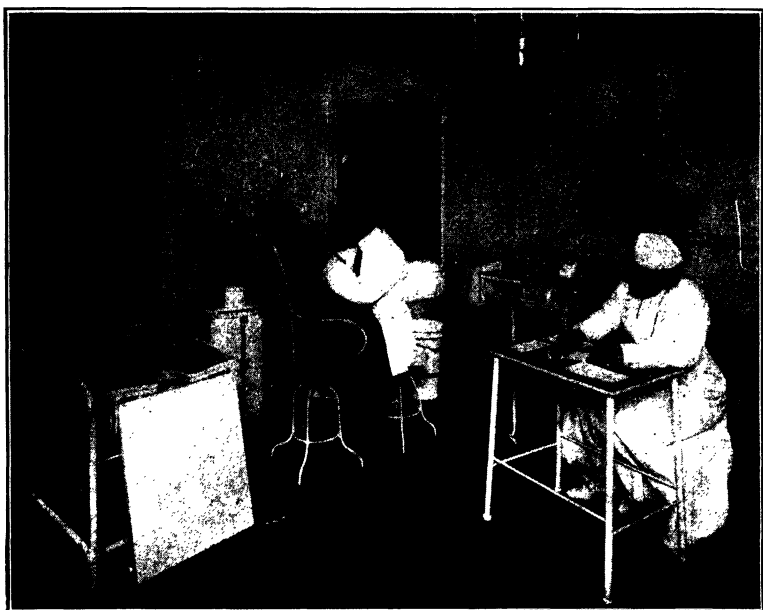
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EXAMINATION AND OPERATING ROOM IN ONE OF THE NOSE AND THROAT
CLINICS FOR SCHOOL CHILDREN MAINTAINED BY THE
NEW YORK HEALTH DEPARTMENT, 1912-1915.

FREE MUNICIPAL CLINICS FOR SCHOOL CHILDREN.

A Review of the Work of the School Children's Nose and Throat Clinics in New York City.

By J. H. BERKOWITZ

Special Investigator, Bureau of Welfare of School Children, New York Association for Improving the Condition of the Poor.

I. Introductory.

What should a community do if the doctors employed by it to examine the children in the schools found approximately 150,000 cases of defective nasal breathing and hypertrophied tonsils year after year?

The City of New York answered this question in a practical way when, in 1912, it established the first school children's clinic for the free operation and treatment of needy cases. In June of the same year there were five such clinics in the greater city,* giving operative and medical treatment to children too poor to afford private physicians or pay clinics.

As an experiment in public health work, done in conjunction with the work of public education, the clinics have been of the utmost importance and significance. The results of their four years** of operation have proved their need and usefulness. Their discontinuance at the end of 1915 is very regrettable, insofar as it is a step contrary to the present-day tendency towards the closer correlation between treatment clinics and school health administration. This review will concern itself with the work done at the clinics and the conditions of health existing among the 900,000 school children in New York City which necessitate such institutions rather than with the question of policy bearing on their closing.

The Bureau of Welfare of School Children of the New York

*Location: *Manhattan*—341 Pleasant Avenue. *Bronx*—580 East 169th Street. *Brooklyn*—145 Lawrence Street, 1249 Herkimer Street, and 330 Throop Avenue.

**The clinics have been in operation fully four years, but complete statistics of their work in 1915 are not yet available.

Association for Improving the Condition of the Poor has made several studies for the purpose of

(a) Ascertaining the effectiveness of the school children's clinics as a part of the medical inspection system.

(b) Offering such constructive suggestions and aid to the municipal authorities as may appear to be necessary for the advancement of the work.

The program of the Bureau of Welfare of School Children embodies, among other activities, co-operation with the health and education authorities for the extension and standardization of the system of school medical inspection to include effective follow-up work and clinics for the free treatment of defective school children.

Practically all phases of the clinical activities have been considered and personal observations made of the methods of operation, conduct and management of the plants. An important part of this study was the examination and analysis of 1,720 clinic case records of children operated upon and treated. Of these, 1,677 contained all the data sought for the purposes of compilation and tabulation, the remainder being variously deficient. As a result, these conclusions were derived:

(a) Medical inspectors make correct diagnoses in all but a very small percentage of cases. When examined by the surgeons, 95.7 per cent. of the children referred to the clinics were found to be in need of treatment.

(b) Nearly all children suffering from defective nasal breathing and hypertrophied tonsils require operation. In this group 94.1 per cent. did.

(c) The "neighborhood" character of the clinics is indicated by the fact that nearly half the number of the children treated came from within one mile of the clinics, while the total percentage of those coming from within one and two miles is 82.7 per cent.

(d) The need of extensive following up is shown by the fact that 20 per cent. of the children registered for operations failed to receive them, while less than 10 per cent. of those operated upon were re-examined at a later date. In this may be seen a shortcoming in co-operation between schools and clinics.

II. Tonsils and Adenoids as Cause of Backwardness.

One of the grave physical defects which the school medical inspectors are charged to detect is defective nasal breathing. Its presence is usually symptomatic of either or both of the twin ailments—enlarged tonsils and adenoids. Although defective nasal breathing and hypertrophied tonsils are listed separately as defects for which every school child is examined, they may be, and usually are, considered together on account of their coincidence. This condition of ill health with mouth breathing as a characteristic, soon plunges the sufferer into a multiplicity of troubles, resulting, in a large number of cases, in retardation. Backwardness in school, according to prevailing opinions, is due as much to physical defects as to mental deficiency. In other words, such children become laggards. "Sixteen per cent. of all who drop out of school do so because of ill health," says Dr. Luther H. Gulick; "and those who have physical defects, such as poor hearing, poor seeing, hypertrophied tonsils and adenoids or decayed teeth, progress through school 9 per cent. more slowly than children who are not so handicapped."*

A detailed study of this question was also made by Dr. Leonard P. Ayres, in the course of which 3,304 children below grade in school were studied.** "That hypertrophied tonsils and adenoids have a distinct bearing on retardation," says Dr. Ayres, "seems to be clearly indicated by the fact that the former are found in 26 per cent. of the dull children and only 12 per cent. of the bright ones, and in the case of the latter the percentage falls from 15 to 6 per cent. A similar condition is found in the cases of enlarged glands, defective breathing and defective teeth. In each the falling off is sharp and consistent as removed from the total normal and bright groups. It is too consistent to be dismissed as incidental or non-significant."

One more quotation from the same sources on the plight of the school child who suffers from enlarged tonsils and adenoids: "Perhaps one of his troubles is deafness. He is soon considered stupid. This impression is strengthened by his poor progress in school. Through no fault of his own he is condemned to failure. He neglects his studies; hates school; leaves long before

*Why 250,000 Children Quit School—by Luther H. Gulick, M.D., Department Child Hygiene, Russell Sage Foundation, New York, 1910.

**Laggards in our Schools—A study of retardation and elimination in City school systems, by Leonard P. Ayres, A.M., Ph.D., New York, Survey Associates, 1913.

he has completed the course and is well started on the road to inefficiency and despondent life.”*

III. Prevalence of Defects Reduced by Medical Inspection and Clinics.

Defective nasal breathing and hypertrophied tonsils as a common defect in school children is next to defective teeth in point of numbers. Between 1909, when examinations for physical defects were first made in the New York schools, and 1915 the percentage of children found with defective nasal breathing and hypertrophied tonsils has varied from year to year, but has been uniformly high, never falling below 10 per cent., as will be seen from Tables 1 and 2.

That the seriousness of the ailment has been forcibly brought home to the parents, with the result that proper treatment was obtained for increasing numbers of children, is no doubt evidenced by the progressive decrease in the number of these cases.

TABLE 1.—PHYSICAL EXAMINATION OF SCHOOL CHILDREN—
DECREASE IN NUMBER OF NOSE AND THROAT DEFECTS.**

Year	Number of Physical Exami- nations Made	Number Found Needing Treatment	Defective Nasal Breathing	Hypertrophied Tonsils
1909	231,081	172,112	43,393	50,934
1910	266,426	196,664	40,946	50,012
1911	230,243	166,368	27,316	34,639
1912	287,469	206,720	21,931	30,021
1913	330,179	230,432	29,057	36,958
1914	308,595	221,632	28,877	36,153
1915	305,665	222,072	29,067	34,378

TABLE 2.—NUMBER AND PER CENT. OF NOSE AND THROAT CASES
AMONG CHILDREN FOUND NEEDING TREATMENT.

Year	Defective Nasal Breathing		Hypertrophied Tonsils	
	Number	Per Cent.	Number	Per Cent.
1909	43,393	25.5	50,934	29.3
1910	40,946	20.6	50,012	25.4
1911	27,316	16.4	34,639	20.8
1912	21,931	10.6	30,021	14.5
1913	29,057	12.2	36,958	15.6
1914	28,877	13.1	36,153	16.6
1915	29,067	11.5	34,378	15.5

*Medical Inspection of Schools, by Luther H. Gulick, M.D., and Leonard P. Ayres, Ph.D., New York, Survey Associates, 1913.

**Tables 1, 2, 3 and 4 are based on the statistical reports appearing in the New York City Health Department's monograph, "The Bureau of Child Hygiene of the Department of Health of the City of New York," by S. Josephine Baker, M.D., Director, Third Edition, 1915. Except: Statistics for 1915, from the Weekly Bulletin of the Department of Health, City of New York, Sept. 4, 1915, Vol. IV, No. 36, pp. 288-290.

Another significant fact is that the persuasive efforts of the medical inspectors and the nurses in the schools were productive of prompt action on the part of parents, as is shown by the large number of cases treated.

In Table 3 is given a record of the character and treatment obtained during the last six years of medical inspection:

TABLE 3.—CASES REPORTED TREATED DURING 1909-1914—
CHARACTER OF TREATMENT OBTAINED.

	1914	1913	1912	1911	1910	1909
Defective Nasal Breathing:						
Operative.....	8,446	6,859	6,288	11,284	8,714	9,974
Medical.....	9,227	8,473	7,056	11,555	14,370	30,122
Hypertrophied Tonsils:						
Operative.....	10,124	8,383	6,239	9,808	10,275	10,757
Medical.....	9,926	9,686	7,898	12,839	16,743	33,396

The treatments reported were obtained, variously, from private physicians, city or private hospitals and dispensaries, and from 1912 on, also from the Health Department clinics. The latter were established upon the recognition of the inadequacy of the hospital and dispensary facilities. Of the needy children receiving free treatment, fully 50 per cent. availed themselves of these clinics. Their numbers, as shown by the following summary, were considerable.

TABLE 4.—SUMMARY OF THREE YEARS' WORK IN THE SCHOOL
CHILDREN'S CLINICS—NOSE AND THROAT SERVICE.

	1912	1913	1914
Cases brought forward.....	1,371	1,778
New cases received.....	2,455	5,466	7,694
Total registered.....	2,455	6,837	9,472
Cases discharged.....	1,084	5,059	8,293
Cases pending.....	1,371	1,778	1,179
Cases discharged:			
Normal.....	341	663	88
Cured.....	689	4,054	5,275
Dropped.....	54	342	2,930
Operations performed.....	571	3,889	5,310
Treatments.....	10,344	22,103	28,975

Resumé:

Cases registered.....	18,764
Operations performed.....	9,770
Treatments.....	61,422

IV. School Children's Clinic vs. Dispensary.

Prior to the establishment of school children's clinics all cases other than those treated by private physicians were sent to the public dispensaries. The crowding at these places, causing the children to mingle with patients of all ages and suffering from many sorts of ills, not only entailed long waiting, but was obviously objectionable in other respects. Furthermore, delays of this sort would often discourage the child so that if not treated on his first visit he would not come again. Large numbers of patients waiting for the attention of a doctor always means hurried diagnosis, hasty treatment, and altogether, insufficient attention to the particular needs of the individual patient. Such conditions yet confronted the necessitous child who was within easier reach of the dispensary than of the school clinic. There is another and more serious side to the question—the manner of operation.

While some institutions refuse to perform operations for hypertrophied tonsils and adenoids without complete anesthesia, because of lack of facilities for the proper care of the patients after operation, a large number of the dispensaries (including out-patient departments of several noted hospitals) operate upon the children in the general clinics and without anesthesia. It will be readily understood that such operations are painful, needlessly so. The child is frightened and alarmed into resisting the surgeon's efforts. What with crying and struggling, the little patient unwittingly but effectually blocks the attempt of the physicians to relieve him of his handicap. Operations are, nevertheless, performed under such conditions, severe nervous shock resulting in many cases. Then comes the great risk of sending the patient home without any precautions being taken to prevent secondary hemorrhage or septic infection of the throat. Such cases, "often of an alarming nature," have actually been observed.* This element of danger in the treatment of nose and throat cases was taken into account by the Department of Health in planning the school children's clinics. Not only must all operations be performed with complete anesthesia, but every care and precaution have been introduced from time to time, the procedure being as follows:**

All operations are performed during the morning. As the

*The Division of Child Hygiene of the Department of Health of the City of New York, by S. Josephine Baker, M.D., Second Edition, p. 102.

**Ditto. Third Edition, p. 142.

operative work and clinic work are carried on in the same building, the morning operations and afternoon clinics give the fullest use of the plant, as well as providing for operation at the time when the child's vitality is at its best.

The children are required to report at the clinic at seven o'clock in the morning of the day of operation, the mothers having been previously instructed as to the necessary care and the use of a cathartic on the previous evening.

As soon as the children are received, they are given a bath and proper hospital clothing, the nasal chambers are irrigated with normal salt solution, and the children are then congregated in the playroom, under the direct supervision of a nurse until time for operation. Every effort is made to keep them interested and entertained during this period.

The operations are performed under combined nitrous oxide and ether anesthesia and the children are required to remain in the hospital for twenty-four hours or longer after operation. All precautions are taken regarding the safety of the children. Extensive use has been made of hypodermic injections of ten to twenty c. c. of normal horse serum as prophylactic or curative treatment of cases of hemorrhage.

The operating surgeons are required to remain on duty with the children until at least one hour after the last case has been operated upon or one hour after any case has ceased to show any serious symptoms.

Emergency lists of physicians are posted each week in the clinic so that, in case of any need of medical care, a physician can be summoned at once.

V. A Record of Efficiency—1,677 Cases Considered.

The following statistical analysis and conclusions are the result of a study of 1,677 case histories made by the writer in the Health Department clinics:

(a) Diagnosis and Disposition:

As stated in the introduction, the clinical examinations verify the diagnoses made by the medical inspectors, as will be seen from Table 5. Of the children examined by the surgeons 95.8 per cent. were found to be in need of treatment. This fact is further strengthened by the results shown in Table 6, to wit.: that 94.1 per cent. of the cases needing treatment required surgical operation.

These records are also significant in demonstrating the coincidence of the two defects, hypertrophied tonsils and adenoids, since 81.7 per cent. of the children needing treatment were found

to be suffering from both of these defects, while 7.7 per cent. were found with adenoids only, and but 0.9 per cent. with hypertrophied tonsils only.

TABLE 5.—RESULTS OF CLINICAL EXAMINATIONS.

	Number	Per Cent. of All Children Examined
Children examined	1,677	100.
Needing treatment	1,605	95.7
Defects found:		
Hypertrophied tonsils and adenoids	1,370	81.7
Adenoids only	129	7.7
Tonsils only	15	.9
Very slight adenoid growth	91	5.4
Normal	72	4.3

With 94.1 per cent. of the cases found in need of operation, of the 1,605 cases needing treatment, it is appalling to imagine what the consequences of neglect would be if clinical facilities were not provided for the removal of these serious defects.

TABLE 6.—CHARACTER OF TREATMENT REQUIRED.

	Number	Per Cent. of All Needing Treatment
Cases needing treatment	1,605	100.
Operative	1,514	94.1
Non-operative	91	5.9

The actual operations performed in the clinics studied were 79.4 of the total number of cases needing treatment, the remainder being variously disposed of, as shown in Tables 7 and 8. It is interesting to note that only sixteen cases out of the 1,605, or one per cent., were referred to private physicians. This means that inquiry by the school nurses showed these applicants to be in a position to afford the services of private physicians. It does not, however, follow that all these applicants wished to receive free treatment without being entitled to it. In some cases parents sent their children to these clinics through misunderstanding. The dropped cases fall into two groups, (1) those in which the children failed to keep their appointments,

and (2) those eliminated for various unstated reasons. Both these classes of dropped cases reach a considerable percentage, as will be seen from Tables 7 and 8.

TABLE 7.—DISPOSITION OF CASES NEEDING TREATMENT.

	Number	Per Cent. of All Needing Treatment
Cases needing treatment.....	1,605	100.
Operations performed.....	1,141	79.4
Medical treatment.....	62	3.9
Referred to private physician.....	16	1.
Not terminated.....	34	2.
Dropped.....	220	13.7

TABLE 8.—DISPOSITION OF OPERATIVE CASES.

	Number	Per Cent.
Cases requiring operation.....	1,514	100.
Operations performed.....	1,141	76.5
Referred to private physician.....	16	1.0
Operation refused by patient.....	46	2.1
Appointment not kept.....	153	10.0
"Operated elsewhere".....	7	.4
Dropped for various reasons.....	151	10.0

(b) Duration of Treatment:

Under this head is considered the length of time intervening between the child's first visit to the clinic and the date of his discharge. It is the rule to make the appointment for operation, if possible, within a week from the day of registration at the clinic, although the extremes reached are one day in one direction and two months in the other. The average duration is 9 days.

Twenty-four hours is the usual length of time spent in the clinic by a child who has undergone an operation. We have not found more than ten cases where this stay has exceeded twenty-four hours. Practically all discharged cases are marked "cured" on the case record cards, in the majority of cases the success of the operation being determined by an examination on the day of discharge. In some cases it has been found necessary to have the patient re-examined at a later date, and the results of these final examinations all appear as "O. K." in the records.

TABLE 9.—NUMBER AND PER CENT. OF FINAL EXAMINATIONS
AND CASES FOUND "O. K." AFTER OPERATION.

	Number	Per Cent.	
		Operated	Examined
Operated.....	1,141	100.	...
Final examinations.....	105	9.2	100
Pronounced "O. K."	105	9.2	100

In all, 105, or 9.2 per cent., final examinations have been made subsequent to day of discharge, the lapse of time between discharge and final examination averaging three days.

TABLE 10.—NUMBER OF DAYS BETWEEN DISCHARGE AND FINAL
EXAMINATION OF 105 OPERATED PATIENTS.

Days.....	1	2	3	4	5	7	10	11	12	31
Patients.....	12	45	7	31	5	2	1	2	1	1

(c) *Distances Travelled:*

Accessibility is one of the deciding factors in the serviceability of the free clinic. To be accessible to the necessitous child the clinic must needs be within walking distance from home or school, thus eliminating the expenditure of money for carfare. This renders the clinic a neighborhood institution, as shown by the computations based on 1,440 cases where the distance travelled was determinable. Allowing one mile as a reasonable distance for a normal child to walk, it would appear that not quite half (47.6) of the children coming to the clinics live within a radius of one mile from it. On the other hand, adding to the number of children within the one mile limit those coming from a distance of two miles or less, the result shows that more than two-thirds (78%) of the children came from within the two-mile zone.

The numbers of those coming from distances within four or five miles is still considerable. Beyond the five-mile zone the numbers become trivial, yet not insignificant, if they are taken as an indication of preference for these clinics by people living beyond these "neighborhood" areas. The average distance of travel for the 1,440 cases is exactly two miles.

TABLE 11.—DISTANCES TRAVELLED BY CHILDREN FROM SCHOOL TO CLINIC.

Within Miles	Number of Children	Per Cent. of Total 1,440 Cases
1.....	655	47.6
2.....	459	35.1
3.....	151	10.5
4.....	104	7.2
5.....	16	1.0
6.....	8
7.....	3
8.....	1
9.....	2
10.....	1

VI. Post Operative and Prophylactic Care.

No data have yet become available to show whether there has been a recurrence of the nose and throat defects in children who have undergone operation at the clinics. The finality of the cure could be ascertained and perhaps assured through follow-up work of the school nurses and teachers. On this point the following comment on hospital treatments, made by an English authority,* may be applied likewise to our clinics and schools:

“It has been said by the advocates of school clinics that hospital treatment for enlarged tonsils and adenoids is unsatisfactory, for this reason—that the operation itself is but the commencement of treatment, and should be followed by systematic breathing exercises, which can be carried on in a clinic, but forms no part of hospital treatment. There is some justification for this statement. I have myself seen cases in which the trouble has recurred entirely through the failure of this part of the treatment, but this drawback can be removed by co-operation between the hospital and school authorities. All our schools have teachers well qualified for instructing the children in breathing exercises, and a notification from the hospital that the operation had been performed, and that breathing exercises were required, would be followed by extra attention to the breathing exercises of those children specially requiring them.”

No less important than the after-care in operative cases is the preventive work which may be done. As yet, no prophylactic principles have been developed for the prevention of defective nasal breathing and hypertrophied tonsils, but there are certain recognized rules for the care of the nose which are of some value. The Health Department in New York, like the authorities

*School Clinics; At Home and Abroad, by Lewis D. Cruickshank, M.D., Ph.D., etc. London: The National League for Physical Education and Improvement, 1913.

in other cities which conduct medical inspection, carries on health propaganda among parents and children. Printed circulars are distributed in the schools, giving instructions in health care, and one of these, relating to the nose, is as follows:

DEPARTMENT OF HEALTH
City of New York
BUREAU OF CHILD HYGIENE

Instructions to Parents Regarding the Care of the Nose

The physical examination of school children shows that in many instances they breathe through the mouth because they cannot breathe properly or sufficiently through the nose.

This may be due to bad habits in regard to keeping the nose clean, or, in a majority of instances, to a growth which is known as "adenoids," and which stops up the back of the nose. In either case, the air is not breathed through the nose, and the child becomes what is known as a "mouth breather."

Constant breathing through the mouth causes the child to become pale, restless in its sleep and dull in its actions. The child often speaks as though it had a cold in the head. Frequently there is an almost constant discharge from the nose.

Mouth breathing renders a child especially liable to contract tuberculosis and other infectious diseases; in fact, the child has very little resistance to disease of any kind.

Every child should be given a handkerchief, and be taught to thoroughly blow the nose several times each day. If, after doing this regularly, the child is still unable to breathe properly through the nose, it is probable that an adenoid growth is present. Such children should be taken to the family physician or to a dispensary for further advice and treatment.

Do not wait too long in the hope that the child will outgrow the condition, for the effect of adenoid growths persisting throughout childhood may injure the person for life.

Have your child's throat and nose examined one month after measles, scarlet fever, or diphtheria.

If unable to employ a private physician and there is no dispensary in your neighborhood, take your child to one of the clinics maintained by the Department of Health for school children.

VII. Conclusions.

1. The clinics conducted by the Department of Health have demonstrated their usefulness in these respects:

- (a) Thousands of children have been relieved of a serious defect which is not only physically devitalizing in its effect but is also a cause of backwardness in school work.
- (b) They have supplied a long-felt want in certain sections of the city where similar hospital facilities were and still are lacking.
- (c) Children of needy parents have been given treatment and care which was beyond their financial means and which in the majority of cases would probably not have been obtained at any of the free dispensaries.

2. The efficiency and value of a system of school medical inspection is judged by:

- (a) Ultimate results, as seen in the improvement of health conditions.
- (b) The character of treatment for physical defects given to the children and extent of curative results.

The children's clinics have not only achieved such results but at the same time have furnished the test for the system of medical inspection. This is to be found in the considerable increase in the number of cases treated and cured.

3. As a practical demonstration of approved, humane and safe practice, these clinics have been emulated by other institutions through the adoption of better methods, to wit:

- (a) Operations performed only with general anesthesia.
- (b) Post-operative bed care for at least 18 hours.

4. The closing of the Health Department clinics will cause an increase in the number of children applying at private hospitals and clinics. Some of these are adequately equipped for the treatment and care of children's nose and throat cases fully in accord with the higher standards of practice.

The Executive Committee of the Associated Out-Patient Clinics of the City of New York in a circular letter dated December 17, 1915, urges upon its members "That suitable facilities be provided to meet this increased demand upon them," and calls their attention to the opinion of the Section on Laryngology and Rhynology of the New York Academy of Medicine, given in the report of the Association for 1913, one of the main points of which was:

"The majority of the members of the Section believed that both tonsillectomy and tonsillotomy are operations requiring the facilities of a hospital."

The circular letter also calls attention to a resolution of the Public Health Committee of the New York Academy of Medicine, concurring in the conclusions resulting from an investigation made by the State Charities Aid Association, to wit.:

- (a) That all adenoid and tonsil operations on children should be done under general anesthesia; and
- (b) That hospitals where adenoid and tonsil operations are performed should be equipped to keep their patients in the wards for at least eighteen to twenty-four hours after operation.



In view of the preponderance of opinion among unquestionable authorities on what constitutes proper method and equipment for this work, it now becomes imperative that the school nurses should endeavor to refer all needy cases of children requiring such operations only to those clinics which are known to meet the foregoing requirements.

5. By the establishment of the school children's clinics the city recognized the principle that such facilities should be provided by the community for those requiring them, on the same basis that it provides free schooling.

6. Having thus acknowledged its obligation, the city should continue this work. It is of no consequence what branch or department in the municipal government is charged with it. The need of such special services for school children is urgent.

The Health Department being now relieved of this function, it might be delegated to either of these departments: Charities, Education, Hospitals. The lack of facilities and conveniences for hospital work in school buildings excludes the Department of Education from consideration. Therefore, the remaining possibilities are the Charities Department and Bellevue and Allied Hospitals.

Arrangements could be made for the accommodation of a larger number of nose and throat cases in the children's departments in some of the municipal hospitals which now have such services. It would also be feasible to establish nose and throat clinics in the hospitals under the jurisdiction of the Department of Public Charities, in which such services do not at present exist. In addition to these there are Bellevue and Allied Hospitals, at all of which the present facilities might be utilized for these cases to a greater extent than they have been. Altogether, seven municipal hospitals offer possibilities.

The Bureau of Welfare of School Children has made recommendations to the proper authorities, embodying the foregoing conclusions.

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